Quality Measures Workgroup: Efficiency Tiger Team
Draft Transcript
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Presentation

Tom Tsang – ONC
Hello. Good morning and good afternoon, everyone. This is Tom Tsang from ONC. While we wait for the Tiger Team leads, Bob Kocher and Charles Kennedy, I'll summarize what we did at the last meeting. We talked about some of the measures within the person-centered efficiency sub-domain and we talked about the readmissions rate, as well as ambulatory sensitive emergency department visits, also the appropriate use of diagnostic imaging procedures and inappropriate site of service between in-patient and out-patient surgery. I believe the comments that we were getting from folks in the last meeting was as we were putting these sub-domains together, person-centered efficiencies, proven care, leading conditions, it seemed like there was a lot of interdependencies and a lot of overlap and the sub-domains may be somewhat arbitrary.

So maybe first, I'd like to ask from the group what folks think about the original framing of this and that we were trying to do this from a contract point of view and should we keep this larger framework of person-centered efficiencies versus provider-centered efficiencies. What do folks think? Karen? I'll ask your opinion on this.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I remember back, I guess, two or three calls where I thought we talked about— At the end of the day for every single patient we want to make sure they receive the most efficient care, right?

Tom Tsang – ONC
Right.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Then I think about it. This is in an EHR world, trying to leverage the HER. So every time, regardless of whether it's an issue of should they not get this antibiotic or should they have had some test done before PCI or, "Oh, my gosh! I didn't even know they were admitted to the hospital last week," I mean whatever it is it's all around every patient, every time, the right care. So I am struggling a little bit with the terminology provider-centered versus patient-centered. Maybe somebody could say it in their words for me?

Charles Kennedy – WellPoint – VP for Health IT
So you want kind of what was our working definition of provider-centered versus patient-centered?

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes.

Charles Kennedy – WellPoint – VP for Health IT
I think what we said on the previous call was that patient-centered would be things that tended to be more closely aligned with a patient's course through the delivery system, so something like a hospital readmission or things that involve transitions in care. Any measures around that domain would be closer to a patient-centered measure because it is, by definition, a patient moving from one area or place of care to another area or place of care, which involves, presumably, more than one provider or frequently more than one provider.

Whereas, a provider-centered measure would be something more directly under the control of a provider in his individual decision-making process. The example I think we used was generic utilization rates. If a physician is choosing between drugs, the choice of a generic or a brand has certain patient aspects to it,

no doubt about it, but it might be something more closely under the control of an individual physician and is, therefore, physician-centered.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Okay. Thank you. That's helpful. I guess also just going through my mind in the background is if the country moves to ACO models of care and even those cases of generic drugs or even if there are drugs you should not get or things that are ordered by the physician, we want them all to be thought of in the framework of for this patient and for this patient population, right?

Charles Kennedy – WellPoint – VP for Health IT
I think so. I think there are multiple dimensions to it and so I think in a lot of the measures we said even if you wanted a population perspective on the measure you would want the ability to slice and dice the information from multiple perspectives. One might be how does this provider prescribe for his particular collection of patients versus how does this population of doctors care for this population of patients. So you'd want the ability to look at it from multiple angles. Again, the categorizations are, admittedly, somewhat arbitrary or perhaps have plenty of overlap, but we were just trying to find some workable framework to have the discussion.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Maybe I can jump in for a moment? In the materials I've prepared some thoughts and notes for the call and you may have gotten them from Tom. I sent some directly to Dr. Kennedy and some that Tom was going to distribute. I tried to think about this, these different dimensions and overall I agree with Karen Kmetik that the measures are what happens to a patient, so there's a patient-centeredness to the measures, as it should be. I tried to capture this idea though that there are different measures that might be appropriate in different settings by creating a two-dimensional table. It's on the second page of the memo I sent around. So the concept would be that one dimension is really a practical dimension and it's a ... order of the costs, hospital and facility costs. Just in rough terms, hospital and facility costs, physician and professional fees for overuse procedures, pharmacy, radiology, so that might be one axis.

Then the other axis on the table is things that you would measure for an individual physician, things you would measure for a small practice, a larger group, a hospital or an ACO, for example. Then maybe that gets at combining some of these ideas so there would be some things that are appropriate at almost any level, so the generic prescribing rate is a pharmacy overuse for physicians, but it could also be rolled up into small practices, large groups, ACOs.

Some of the facility measures would be appropriate for physicians, so the appropriate site of service for surgical care could be related to a surgeon. It could be rolled up for small and larger practices, but things like readmission rates would only apply to the largest group for two hospitals or two ACOs. So that's a framework that I think tries to capture maybe these two dimensions. I would be interested in people's comments.

Charles Kennedy – WellPoint – VP for Health IT
I am trying to find that e-mail. When did you send it?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I apologize. I sent it right before the meeting. I think Tom may have distributed it to others. I sent it to Charles.Kennedy@WellPoint.com at 12:57 Central Time.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I'm just looking at it now. So I'm certainly with you when you talk about sort of a category of being pharmacy. In that case, yes, it's pretty relevant to all of those different levels, right? But what's important is for this patient is were they offered the generic drug.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. Individual measures our patient ....

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Right. So when I look in your first column, when you say pharmacy it's not that you're holding the pharmacy accountable; it's a pharmacy related measurement.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Okay. So, similarly, when you say physician overuse it's really there are a set of things around procedures or diagnostic tests or etc. that everyone agrees should not be done. That's important for every patient and that's important across all of those levels.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Right. You could roll into your comment and one of the earlier comments, you could measure that at an ACO level. How many X were done? Then you could break it out down to physicians, perhaps.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Right. So I'm just having a little problem with the consistency of the terms you use in your first column—

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Where some of them I get it; radiology; imaging for diagnostics and pharmacy drugs. Physician use and overuse of the hospital facility to me are different ... and so I was just trying to think, if I'm with you, that the first column is sort of the buckets of things that we think we need to address. Right? We're not. We're addressing drugs or something about drugs. We're addressing imaging or something about imaging. We're not addressing hospital facilities per se. We're addressing something about it.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I got you. I guess my terminology could be clearer so that what I was trying to capture was the appropriate site of service, appropriate level of care in the hospital facility overuse or misuse of the ER, something of that flavor and then physician related issues. So we have broken out into like diagnostic procedures or therapeutic procedures so the things that the physician generates and that's kind of similar to radiology generated.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
So if we're saying the same thing then I guess my question is sort of on a diagonal here, right, or on the second dimension is leveraging data in the EHR. Right?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Right. That's what we're about here. So I'm just wondering sort of how do we factor that in. I mean I just used the readmission as the common example, so you can get that information now from claims to try to push us to say we have this golden moment where we're trying to say you invested in EHR. We want you to use it this way because this is going to give us something never before we had and it's going to help you whether you're a ... or hospital or large group or whatever. It's going to help you to provide the most efficient care to your patients.

I just want to make sure we keep in mind that second dimension or that diagonal so that as you populate these boxes it's really striving to leverage the EHR data, which I think is what Tom or ... were saying on the last All Group Call. Does that make sense, Tom? I don't know. Does that make sense to you?

Tom Tsang – ONC

Yes. I guess we're trying to come up with semantics and labels here and it seems like we're actually going back to what we had originally started off with, which is, Karen, you just nicely outlined this broad category of procedures, whether it's diagnostic tests or procedures and then this broad category of drugs. Within that you're going to have measures that are applicable for both consumers, patients and providers and hospitals. Then, with medications you're going to have measures applicable to those relevant groups also.

So, I guess for me it's kind of really I'm agnostic to really the framework that we're working under as long as we come up with the right measures, but I just want to make sure that folks all agree to somewhat of a framework, because we seem to be going back and forth about the framework itself.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Can I just respond to two things, Tom? Then I do want to hear the answer to your question too.

Karen, I agree with you and I'd like to also think about some of the EHR potentials in a broad way, so even though readmit rates can be measured off of claims, as an example, you could also push that information back up to an EHR in a useful way, so Dr. Smith, your patient was readmitted and you wouldn't know that except that this system pushes that back to your EHR and—

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Absolutely. I am with you, Rob, and I just think for us to just be clear in our wording so that we do motivate that.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Very good. Bob Kocher last time did kind of challenge us, I think on Friday's call, to think even beyond the EHR, but I did want to acknowledge your comment, Karen.

Then the second thing, Tom, to your point about creating a framework, to a certain extent I agree with you and I popped this together to help us be complete, so that we don't leave an important area unturned.

Tom Tsang – ONC
No. This is very helpful. Thank you, Rob.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
But anyway, then you did ask a question of what people think and I do want to hear comments on that too.

Tom Tsang – ONC
Charles, are you back on? No. We lost someone. Hello?

Jon White – AHRQ/HHS – Director IT
Tom, I'm still here. It's Jon White.

Tom Tsang – ONC
Jon, do you have an opinion about the framework?

Jon White – AHRQ/HHS – Director IT
Not yet. It doesn't mean I won't eventually have one, but—

Tom Tsang – ONC
Is there anyone else? Kate, are you back on?

Kate Goodrich – ASPE – CMO
I sort of agree with you, Tom, but I'm kind of agnostic to it as long as we get the right measures.

Tom Tsang – ONC

Yes.

Kate Goodrich – ASPE – CMO
... this one I need to probably absorb it a little more. The problem I had with the other one was what I think others had, which is sort of the overlap issue and trying to put things into separate buckets, so for me this one makes that a little easier. There is still some overlap, but I don't find it quite as problematic, at least at first blush. So I'm fine with this one. But to me, as you said, the more important thing to me is that we get the right measures in place, so ...

Tom Tsang – ONC
All right. So how about this? Let's move forward then. Let's stick with the framework that we have for now and perhaps at the end of the day when we have a set of measures we can always work backwards and readjust the labeling and the names. So, as I said, the patient-centered efficiencies; we talked about readmission rates, ambulatory sensitive, emergency department visits, diagnostic imaging, procedures and appropriate use. There are three different areas: Redundancy, cumulative exposure; Rob pointed out nicely in the last call about there's evidence of cumulative exposure and that's a patient safety issue and appropriateness; and then the last thing is inappropriate site of service between in-patient and out-patient surgery.

Now, are there any what I would say more notional or aspirational measures that people could think of or have, perhaps, over the last five or six days have been burning in your mind about what's in this category that we should certainly point out to the group?

Kate Goodrich – ASPE – CMO
I'm sorry, Tom. Your category again is?

Tom Tsang – ONC
The category is patient-centered efficiencies.

M
Tom, you're working off of the—?

Tom Tsang – ONC
I'm working off of the spreadsheet that we sent off, which is a summary of our last two discussions.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes, that Susan ... sent Tuesday.

Tom Tsang – ONC
Right. Now, Rob, you sent a bunch of new measures for us to consider. Would any of those measures be applicable to this category?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. Let me just go through person-centered efficiencies. We talked about the readmission. We talked about ambulatory. There is really, I think, quite a few that would go into this. I'm just flipping through your table, Tom, just to make sure I don't have too much of an overlap. Give me just a second.

One attachment I sent was a list of overuse measures that ... and I had come up with. Karen, you've probably seen this before, this list we sent to the CPCI last spring. There are actually about 55 different things in here, but to give you a flavor, there are things that relate to procedures, so elective inductions, pre-term c-sections—

Tom Tsang – ONC
I'm sorry, Rob. Is this the Added Measures PowerPoint or is this the—?

Robert Greene – United Healthcare – Vice President for Clinical Analytics

It's the Overuse Measure Summary.

Tom Tsang – ONC
It's the Version Two Excel spreadsheet?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. So if people open that up, there are a number of things. By the way, we've presented this in a general way. Some of these obviously wouldn't apply to Medicare, although they would apply to the Medicaid population, so elective inductions, pre-term c-sections, hysterectomy approach, lumbar fusion rate and actually, developing a metric with that with the advice of some of our scientific advisory boards, fusions, ... fusions out of all lumbar fusion and laminectomies.

Many of the surgeries we need a little more information in terms of appropriateness and things that may come from the chart also have to be driven by the specialty societies. For example, if we have appropriateness indications now the cardiologists have developed some for many of their procedures, but for things like mini-mastectomies, arthroscopies, the various procedures and such. This also includes a number of radiology measures and some pediatric measures too, so the absolute lifetime CT scan exposure is in this long list. I think those are the major patient-centered without going into excruciating detail.

In the PowerPoint that I attached, we had sent this in earlier in the year and the constraint in that PowerPoint was related to the request that things be NQF specified, so there are a number of specific NQF measures and some of them we just talked about. I'd draw attention to the care coordination, which is, I think, a patient-centered measure of discharging and ACO care.

Then lastly, in the long memo I included a number of cost efficiency measures that are kind of more generalized. We've talked about some of them: The readmit rate, but also the number of admissions themselves, chest pain one day admissions. The ER visits we talked about.

Lastly, we're working on some population cost measures to understand how well primary care or other entities are managing a population, anticipating, for example, some of the ACO population management or ECMH population management members. That's in Appendix A of the memo.

I think I'll pause there. Again, I apologize for sending so much material out at the last minute. It took a couple of days to assemble some of the stuff.

Tom Tsang – ONC
Reactions to some of these measures? Rob, I think the care coordination measures are fantastic and they would be very much aligned with, I know, some of the work that the Care Coordination Tiger Team is talking about. Then the measures for the Population Health, that would fit nicely within that domain when we get up to that.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Very good.

Tom Tsang – ONC
Karen, you weren't here on the last call, but do you have any reaction to what we have so far for the person-centered efficiencies? Do you want to respond to what Rob just talked about? Do you think we've left off anything that perhaps we should consider?

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes. I'm trying to quickly digest this and I think I don't disagree with any of this as being important and certainly a great deal of it is stuff that we've been working on or are working on. I guess it's just at the end of the day it would just be important to keep coming back to; how do I say this; how would these measures, by being incorporated into an EHR, be likely to make an impact? Maybe that's just beyond the

scope of where we are right now. We're trying to get at ... the area of efficiency here are topics that we think are important and there has been some work on.

Tom Tsang – ONC
Right.

Bob Kocher – McKinsey & Company – Associate Principal
It's Bob Kocher. I apologize for being late.

Tom Tsang – ONC
Hello, Bob. We kind of summarized the last two meetings and we agreed to stick with this larger framework that we talked about, patient-centered efficiencies, proven care, leading conditions. We went over the measures that we had for person-centered efficiencies and now I've asked and challenged the group to really think beyond these measures and perhaps look into other measures that we've not thought about. Rob just pointed out some of the work that they've been doing at United.

Bob Kocher – McKinsey & Company – Associate Principal
Excellent. Okay.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I think it'd be great to have kind of three buckets so maybe ... you've already suggested ... sort of measures that are already approved and make sense that we all sort of agree on, areas where we have ... or maybe ... measure ... all of the way and then there are sort of ambitions for where the ... methodology ... metrics ....

Bob Kocher – McKinsey & Company – Associate Principal
Okay.

Tom Tsang – ONC
Karen, I'm sorry. We interrupted you.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I was going to throw out, in thinking like you said, Tom, a little ahead, forward and I don't know if this falls under the category of efficiency or one of the other categories, but thinking about just for many areas where if the patient is not at goal what's being done. So I mean it kind of has an efficiency hat to it in that you say well, if you have a patient with hypertension and it's a year now and they're still not controlled and they're on the same drug regimen that's probably not good, efficient care. So, I don't know how to phrase it, but I just wanted to throw out there measures that look at what's the action being taken if current protocol is not producing the results the patient and the physician want.

Tom Tsang – ONC
So can I articulate that in an ACO example? For example, let's say if we used IVs, for example, and we know Hb1cs less than 7.0 would be optimal care, but if the patient is going through the primary doctor's office, the endocrinologist's office, as well as the nutritionist's office within the context of an ACO and they've also had a hospitalization for ketoacidosis can we come up with a bundle of measures that would measure across the various signs of care and seeing if everyone has complied to the evidence to bring that Hb1c to less than 7.0 or to optimization of diabetic care. Is that what you're suggesting?

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes. It's almost maybe sort of the Delta concept. Is there progress being made towards goals? In an ACO world that everybody is aware of what the goal is for that patient. I'm not being very clear just because I'm knowledgeable in hypertension I keep going back to that. They've done this at Northwestern. We have these patients and they're still not at the appropriate goal. Have I tried another drug regimen? Have I tried promoting healthy lifestyle? Have I tried what are the steps versus if the measure is just a goal, not taking advantage of the EHR to help get to goal?

Tom Tsang – ONC
Do they take into account, I guess, lifestyle issues and other aspects of care provided outside the primary care doctor's office?

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Again, aspirational certainly could, right? Then it goes back to ... is there a way that everybody is seeing that same information in the EHR within an ACO for that patient?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
This is very, very interesting and I think, Karen, there are two important aspects. One is that, of course, controlling the blood pressure decreases bad events down the way, strokes, heart attacks, etc. The other is if we had the blood pressure reading through the EHR we can tell how much a year of blood pressure treatment cost and I've done some work decomposing those costs so you can actually tell the difference between what one physician is doing and another physician to generate a year of hypertension care. What you would wind up, if you had the outcome and this could be applied to a lot of different intermediate outcomes like hemoglobin a1c to LDL, is you'd be able to do a frontier analysis in economic terms, right? Because you'd get points, which were this amount of control for this amount of dollars and you could then know how to move towards the best control for best cost, so that's an actual efficiency measurement.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Right. That's also getting towards CER.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Right. So you can save X dollars by using generic antihypertensives, but I think you can save double that by getting the blood pressure where it needs to be using the right combinations or fewer combinations or whatever, plus the effect of decreased adverse effects, which is the most important goal.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
So at the moment the physician or their hospital is looking at their EHR they won't necessarily, at that moment, have your good analysis, Rob. They might be down at the management level—

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
But, if we enable and promote the use of the EHR to look at these options I'm not phrasing it right, but yes, it's along the line of what you're saying. But I want to bring it down to what can we do with the EHR in the physician office or the hospital to get us to an analysis that you could do.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Well, the first step is ... the gaps. You're continuing to have a gap. There might be an element of decision support and CPOE folded in, right? So the decision support would say the next medicine to add is a diuretic and here's a list of generics on the formula. Right?

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Right. Yes.

Tom Tsang – ONC
So you're essentially saying the most efficient, high quality care from an individualized care plan for that individual.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes. Exactly. Yes. I think that's an aspirational goal right now.

Tom Tsang – ONC

Right.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
... operationalize that. It's going to take some thought, but I would just like to leave that out on the table; that to me that's a great holy grail.

Tom Tsang – ONC
So if the patient has three chronic diseases, diabetes, hypertension and CHF, what's the most optimal medication regimen, lifestyle regimen or any other type of intervention that could bring about optimization of those three chronic diseases without inducing harm and yet is the most efficient?

Jon White – AHRQ/HHS – Director IT
That's a great aspirational goal. I will just underline the fact that there is not great evidence about what that ideal regimen is as far as I'm aware.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
There are some diseases where there's a step-care approach and so hypertension would be one example and diabetes ADA start out with drug X. If that doesn't work, add drug Y.

Jon White – AHRQ/HHS – Director IT
I'm sorry. I should clarify. Absolutely for the individual, where you have multiple co-morbid conditions there are certain treatments that are shared in common, right?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Jon White – AHRQ/HHS – Director IT
You would definitely want to say, "Okay. This diuretic hits these three conditions. You really ought to be on that." I'm just saying that there's not great evidence about what the ideal regimen is and if you have to prioritize within that what do you hit first and that sort of thing. That's what I was trying to say.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes. Good point, Jon.

Tom Tsang – ONC
Very good.

M
It may not matter actually all that much though. I mean if you think about it, achieving one might lead to the other one too though.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I think some of this is there is so many measures and there are so many possible things, so there is some prioritization activity, which is partially why I chose that framework in terms of high cost things first or highest cost things first. Then there's this other dimension, which is showing some of the gaps in what we need to do, so the ADA helping with what's the first thing to work on for diabetics and sometimes it is blood pressure. So there are some steps towards that, but some of this for more isolated diseases might be closer. It might be nearly there.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I have another aspirational goal to throw out if you all could stomach one more. Most of what we talk about is reliant on having a patient with a diagnosis and, of course, a lot of our measures all start out that way because if we had to go through claims we needed to have an indication that the person that the person had heart failure, the person had hypertension. But in an EHR we could actually begin to identify people who are not diagnosed.

Now again, Rob, you can help me translate this into the economics of efficiency, but we're trying to say we don't have to start any longer with do you have an ICD-9 diagnosis of hypertension, however that's defined. Jon, you would have to help here, but if the evidence says three or more blood pressure readings that are elevated one should consider an intervention you could begin in an EHR; again, I'm trying to leverage that EHR; you could query for those individuals, who may not yet be diagnosed.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes ... for every point of EMI ... hour of claims cost roughly ... can be more exact, but things like that one could use as a metric for an intervention point. That combined with some clinical data points, as you're suggesting, could create huge value from a health value perspective.

Jon White – AHRQ/HHS – Director IT
I agree with that completely. You want to get really aspirational? You try to identify the people that are at risk before they get sick and figure out how many you've kept from getting sick. That's like wow, crazy, future, but—

M
Dean Nelson is actually doing that with his Dartmouth project.

Jon White – AHRQ/HHS – Director IT
Yes. If I knew that we could do it in a sustainable and replicable way I would love it. But, yes, I know there are folks out there thinking about this. Yes.

M
They've put together a risk assessment tool along with a functional status assessment tool and then they have a third survey looking at your comorbidities and they can come up with what we talk about, an individualized treatment plan that supposedly can deal with more on a population level. So I think that's what they're going to try and do with some of their high performance network collaboration projects.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Because I had goose bumps when you said that Jon, it is aspirational, but why can't we start to articulate that and say maybe that's not exactly what we're going to achieve, meaningful use 2013 or even 2015, but if we want to get there in 2020 what can we do leveraging meaningful use EHRs in 2013 and 2015 to set the stage for that.

Jon White – AHRQ/HHS – Director IT
That's why I work here, right? Yes. I'm with you.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
The trick is translating that backwards, saying that's an end point we want to get to. What are some very meaningful steps along the way that might be worth putting on our table?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Tom, this is great and I totally support this stuff. We're doing some risk modeling in my department, not quite as sophisticated as that and the stuff we're pulling off the claims, which is pretty interesting, but I want to come back a little bit because I think one of the issues we have to face is the right mix of aspirational for the future and aspirational for right now.

Tom Tsang – ONC
Yes.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
There's such urgency to all of this and I think, as a group, as we sort these ideas out so Bob Kocher had what's approved now, what's conceptual and what's ambitious and—

Bob Kocher – McKinsey & Company – Associate Principal

Yes.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
And had that same dimension for right now, which I think we should talk about some more as well—

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Can we, as part of our report going forward say that we recognize that, but I think if we don't articulate that future and some steps we could take now then every year we're just going to be trying to put out the fire.

Tom Tsang – ONC
Yes. I think what we'll do is we're going to put together all of these thoughts and at least categorize some of the concepts and notions into what's already the primetime, ready to go and what needs a little bit more work, at least in terms of intermediary goals and then what's beyond like 2015 and beyond, so yes. I think what we'll do is organize in such a way so that all of the workgroup members can react to it over the next several days.

Jon White – AHRQ/HHS – Director IT
Karen, at least on the federal side, throw it all out there on the table. You do have folks from ONC, AHRQ, ASPE, CMS involved with this group, plus there will be the report out. Some of this belongs here. Some of this belongs other places, but just go ahead and put it on the table now and we'll get it sorted out.

Tom Tsang – ONC
Okay. Bob, are you on the call?

Bob Kocher – McKinsey & Company – Associate Principal
I'm here. Yes.

Tom Tsang – ONC
I'm wondering if we should move on to the provider-based domain. We talked a lot about pharmaceuticals in the last meeting, specifically antihypertensives, antibiotic appropriateness, generic versus brand usage, formulary adherence rates, physicians reacting to e-prescribing interaction alerts and then lastly, acute migraines, who receive prophylactics. Any other thoughts that you may all have come upon over the last few days?

Bob Kocher – McKinsey & Company – Associate Principal
As I was thinking about it, there are two spots where we might have admissions. It may be okay. I'll throw them out there. For pulmonary we don't have anything about appropriate either COPD treatment or inhaler use. The other one that just stuck out as I was reflecting was for statins. We have people who are treated at goal not being treated at all. That's actually one of the only areas where there is actually real mortality benefits or easily proven mortality benefits I should say.

Tom Tsang – ONC
Okay.

Bob Kocher – McKinsey & Company – Associate Principal
I mean I'm not necessarily passionate that we have them, because there is something to be said for eloquence or elegance, meaning that of metrics that we have, but others who agree with me also have observations for gaps and ... useful to have.

Tom Tsang – ONC
So, for cardiac are you specifically talking about just the antilipidemics?

Bob Kocher – McKinsey & Company – Associate Principal

Yes. I mean there are patients, who have hypercholesterolemia at goal, which you would sense if you measure.

Tom Tsang – ONC
Reactions from the group?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I think that's very important and I support that totally. There are a number of other prescribing things, which are preventive. I put some of those in Appendix B of my memo, so things like aspirin use .... Now, right now that's a survey measure, but in an EHR you should be able to get aspirin and antiplatelet use.

Tom Tsang – ONC
Yes. That's true. Thank you, by the way, for those documents. They're really good.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
You're welcome. Then there are a couple of other things related to heart failure and coronary artery disease, so ... ace inhibitors.

Tom Tsang – ONC
Yes. Ace is very interesting. What do you do, just ... and aces and are agnostic about them?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes, but I think the NQF approved measure is either and then like the discussion we were having before about blood pressure control, this is a place where the EHR with prescribing support and clinical decision support can go are you sure you need an ARB. I think those are all brand name now.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I'll throw something out again. Again, I don't know if this goes here, but improving care. I don't know if adherence goes here or not, but the notion of putting back into the EHR information on whether the drug was dispensed.

M
That's a great suggestion, I think, for if not now, like near-term innovation on how to match ... receipts or ... with orders in the EMRs to figure out adherence and compliance.

Tom Tsang – ONC
So incorporation and getting a feedback mechanism of all of the PBM data back into the EHR?

M
Yes. Your plans can get that data. I mean the plans know if you filled it. They don't know if it was ordered. If you ask them if they ordered it, if you can imagine a system where—

Tom Tsang – ONC
Well, folks are even talking about a step beyond that, about the electronic chip in the pill bottle. Yes.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
... I can't stop building on meaningful use momentum, right? So we've got e-prescribing ... that we've got a big issue in this country of adherence. We've first got to have that discussion between physician and patient, but the physician never knows. Now, that doesn't mean the drug was taken, but the physician doesn't know was it even dispensed.

Tom Tsang – ONC
Right. I know at least within the vocabulary terminology framework that NQF is using within the QDS model they actually have a data element called whether the medication is dispensed or not.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Yes. We've talked with some folks here in Northwestern and even if they do get the data back, in this case, from the pharmacy, it's not reliable or accurate to be actionable. So, some work to be done there. Maybe it's aspirational, but trying to build on the ground work of meaningful use stage one.

Tom Tsang – ONC
But, Karen, going back to your notion of actually bringing about CER research at the point of service, how would we measure proving evidence based care, how whether it's the blue pill versus the red pill, how do we measure that?

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I guess I was thinking more along the lines of if we begin to collect that data about what's being done for each patient that contributes to the data that will be needed to do clinical effectiveness research. I don't know what a measure would be, but I was thinking more you begin to see how the data from the EHR builds the whole platform for our research going forward.

Tom Tsang – ONC
So if we have a system that has, let's say, 30 CDS rules built in and if there's a pop-up or something, you're seeing the patient for diabetes and for some reason you miss the opportunity for giving an ace inhibitor for a proteinuria that would be a missed opportunity and that would be within the measure?

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes, within the measure, but I was thinking more broadly that we talked about hypertension and we said we'd like to know were they on just one drug or did they add the diuretic or is the patient being counseled on healthy lifestyle. If you could start to accumulate that data my patient and then to what Rob was saying, you could begin a nationwide research project, right, to say what are the costs to care for somebody in a given year and what seems to be having an impact in real world as opposed to just randomized control trials.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I mean you could also get kind of total cost of ownership, if you will, of various approaches to care. It ... powerful ... ACO and ... savings let's say. That would be a massively useful bit of data.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
So that notion doesn't translate in my mind easily to here's the measure for meaningful use. It's just sort of a concept to keep in our minds.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Well, it would be the data set to get. The measure would allow you to do other things.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Right.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Are you entering the data in this way and it's ... in this way because we think five years from now we could do a really interesting study on the efficiency of hypertension care in this country.

Jon White – AHRQ/HHS – Director IT
Since we're delving into sort of effectiveness I think it's probably worth mentioning a reasonable amount of the investment that AHRQ has recently made in comparative effectiveness with the electronic information structure to be able to conduct comparative effectiveness research. Most of that, in fact, all of it does not address costs or efficiencies, because that's very clearly kind of out of balance for the funding that we've put out there. So when we talk about comparative effectiveness work, yes, I'm also enthusiastic about the potential of the information infrastructure to be able to help us conduct that kind of

research, but just know that the work that has recently been funded by AHRQ and CER is not coupled to efficiency issues. In fact, there's kind of a firewall there.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Jon, so you're explaining to us that the comparative effectiveness is literally just clinical effectiveness?

Jon White – AHRQ/HHS – Director IT
Largely and again, you all are talking comparative effectiveness much more broadly. I'm from AHRQ, so I just want to make sure that I'm clear about the context of the work that's been funded by AHRQ recently. There's a lot of work that is going to take place in the next year or two or three trying to address electronic data methods for conducting comparative effectiveness research. Costs are off the table in that work that's going to move forward. That doesn't mean that in the broader field that's off the table, but for the AHRQ work it's off the table.

Tom Tsang – ONC
Well, I think added a few more measures and aspirational measures for the proven care. Should we move on to leading conditions? We've talked about, going back to the outline, average number of hospital days for beneficiaries of selected conditions, percent of post-acute care stays without a hospital readmission ... avoidable admission indicators. Susan, do you need some clarification on some of these measures that we talked about?

Susan
Do you mean the ones that we were just conversing or the ones that Niall added to the spreadsheet?

Tom Tsang – ONC
The ones that we just added to the spreadsheet from last week.

Susan
From last week I know one area that we briefly ... that a lot of these seem to be very kind of hypothetical measures that we don't necessarily have the grounding in which NQF measures will be used as a reference. That was one area we discussed.

Also on the spreadsheet we have the measures we talked about last week, but we also still have some that folks, I think, Niall, for instance, added a bunch for leading conditions that you just read through, which is background ....

Then additionally, we've talked about a bunch just within the last hour or so and I think I have a general concept for the notes that we can start from, but I suspect that those will also need further elaboration once folks are able to see what the outcome of the last discussion was.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Would this be the place—and I see it in the patient-centered—Tom or Judy, to clarify, this is for the CMS leading conditions, so it's a little more specific than where we've talked about all cause readmission and all cause length of stay or such. Is that the idea?

Tom Tsang – ONC
Yes. I think we lumped the readmissions here because I think when we were starting to talk about readmissions it was physically focusing on the types of heart failure, pneumonia and acute MI.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Tom Tsang – ONC
So if you'd like to add to that list some of the things that you mentioned earlier on this call we can add it here. Also, we can actually add other specific chronic diseases here and any effective or efficient care measures that we would like to add. For example, the pulmonary diseases, if we think about those and,

Karen, I think you guys are actually working on a number of these in AMA as well, right, for very, very specific conditions?

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes. I'm just wondering if maybe I should put that together after the call and send it to everyone.

Tom Tsang – ONC
That would be wonderful.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Right and some of the general utilization measures, of course, you could break down for the individual leading conditions—

Tom Tsang – ONC
Who is this?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I'm sorry. Rob Greene speaking for transcription purposes. So I like to do the roll up overall and then the breakouts, so there's adjusted length of stay, but then there's adjusted length of stay for XYZ conditions. Then all of those other things, the emergency room visit rates, the emergency room escalation rates. Those could be leading conditions or generalized.

Tom Tsang – ONC
Rob, what about on your spreadsheet on proposed overuse measures? You have a lot of orthopedic procedures here—

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Tom Tsang – ONC
So would you consider the knee replacement and hip replacement, would you consider lumping those under this category?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. I'm trying to use this framework and since putting it into this framework, probably yes, right? So you'd have probably like rows 30 through 36 for a bunch of orthopedic things, so as I mentioned, the lumbar fusion, 29 through 36, the lumbar laminectomy and fusions. I don't know the Medicare data. I know in a lot of situations, in Medicaid situations, injections for low back pain are overused and then the various large joint procedures.

M
The other thing to add is the imaging for back pain, which I think we have in another ... somewhere else, but ... Karen was ... potential.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Niall Brennan – CMS/HHS – Deputy Director
Hello, everybody. It's Niall. I'm sorry I'm joining late.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
In the future state category I'd be curious ... reaction to some type of major around productivity or functional status of people with these conditions, because we have a lot of sense of either overuse or under use or ... and clinical practice, but really what we care about is going to be sort of are people living with pain. Are they able do their activities of every day working if they're of working age and that kind of

stuff? That's where the data – I've never seen great metrics on the aspects of that. That's kind of what we'd like to have this for.

Tom Tsang – ONC
Niall, just to bring you up to speed, we're working off of the Excel spreadsheet that Susan had sent a few days ago.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I just about jumped off the chair when you mentioned that, because it's such a big omission in what I sent and such. Yes. Absolutely. So many of our measures are process measures and intermediate outcomes and such, but yes, pain. Did the surgery for my knee reduce my pain? Did the surgery allow me to walk 100 feet instead of 10 feet?

Tom Tsang – ONC
Obviously, those aren't ... yet, but since we get to play science fiction and ... stuff that we wish we had I ... functional status.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Let me counter that a little bit. For transcription purposes, this is Rob Greene still speaking. In the pain measurement world, the 1 to 10 scales and the visual scales and such are well validated and a difference of two units represents a significant change in pain levels, so the EHR is kind of perfectly situated, right? Because the orthopedic surgeon or the primary care in follow up would say, "What's your pain on a 1 to 10 scale?" We would then have that information and that really would be critical. Some of the basic functional things, like walking, there are some measures already; they're not NQF approved, but I know for spinal stenosis and walking distance on a treadmill. So I think we're not too far for some of these things. Lastly, I'd say that the SF12 and SF36, those things could be modified to be disease specific and there is some interest in doing that, so I think those are things, especially the pain one, that we're pretty close on.

Bob Kocher – McKinsey & Company – Associate Principal
That's encouraging. To me, ultimately we want to just store outcomes and efficiency is the combination of input, input cost and then the value creation of the delivery, which then ... we would like to measure more outcomes and so ... we have a few ... how to get there, for instance, on pain for orthopedic. We should put that down unless somebody, people disagree. I think the concept though for common diseases if we have ways to get towards more functional outcomes in future versions that would be a valuable thing.

Tom Tsang – ONC
So would those be applied specifically for leading conditions, Bob and Rob?

Bob Kocher – McKinsey & Company – Associate Principal
I would propose that we would do it for leading conditions, which I would define by probably the total cost because that would give us a good ... of people and spending. I would think the top 15 conditions, let's say, would be the initial targets. Maybe we supplement it; I suspect that our friends at AHRQ or CMS, there might be also some conditions that are just have woefully large opportunity and then do we supplement that with ... targeted areas too that are outside of the top cost areas, but where there is the greatest opportunity to improve.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. Rob Greene here. We're doing a project on patients with chronic pain and 55% to 60% is back pain and 30% is cancer pain, so there are two out of the top six, top ten there. As I said, for a lot of the orthopedic things, again, the literature is varied, but there are a number of functional tests, so that one the work is done, but a lot of possibilities.

Tom Tsang – ONC

Great. Wonderful. I wanted to ask Niall, since he jumped in and we are talking about the measures that you had proposed, Niall, if you want to just give us a little bit of what you were thinking of in terms of suggesting average number of hospital days and percent of post-acute care stays? This is for leading conditions.

Niall Brennan – CMS/HHS – Deputy Director
Yes. I'm not necessarily sure what bucket they fall into, but again, my motivation was getting at sort of metrics of resource utilization that ultimately get at efficiency and that can be calculated reasonably easily. This is why I struggle, because I still very much live in a claims data world.

Tom Tsang – ONC
So isn't it really going back to the old DRT methodology?

Niall Brennan – CMS/HHS – Deputy Director
I don't really think so. I mean, for example, percent was supposed to be the care stay without a hospital readmission; I think that is very, very important, both from a quality perspective and an efficiency or resources perspective. I mean the more you can successfully keep people out of the hospital is just ... just a twist on a readmission measure, but focused on post-acute care setting.

Tom Tsang – ONC
So do we have national benchmarks that we can—? I mean when we measure folks do we have national benchmarks to actually shoot for, for example, like CHF, pneumonia or even cancer?

Niall Brennan – CMS/HHS – Deputy Director
There are certain research studies out there. I didn't realize that. Do we need national benchmarks for these things in order to include them?

Tom Tsang – ONC
No, probably not, but I'm just curious.

Niall Brennan – CMS/HHS – Deputy Director
It's a non-trivial amount. I mean for certain populations, Medicaid, Medicare, dual with specific conditions you're talking between 20% and 30% of post-acute or long-term stays having admissions or readmission somewhere along the line.

Tom Tsang – ONC
Yes. Well, this would be a critical measure actually if you guys are thinking of kind of like a reverse readmissions policy towards long-term care folks.

Niall Brennan – CMS/HHS – Deputy Director
Yes. Again, not to be a one-trick pony, but the PQI, avoidable admission indicator at the ambulatory care center of conditions, I think most people are familiar with those and then I'm kind of in a big ACO space at the moment, so thinking about the number of providers who touch a given patient, again, I don't know; I think it's of interest to the system. I think it also might be of interest to a provider to know who else the patient is seeing as they're seeing the patient, because then that can also have sort of trickled down. Well, did you get this or that from another provider? I'm thinking almost like verbal interaction. I'm pretty sure that there's probably a fairly high correlation between resource use, between the number of providers seen by somebody and the level of their healthcare resource utilization.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. In support of that, Niall, would be ... work, right, about patients seen in the last six months and the number of specialists and the resource use?

Niall Brennan – CMS/HHS – Deputy Director
Yes.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Then to carry that into the EHR and ACO world, conceivably the EHR ... specialists, would at least reduce ... and give everybody better information and perhaps also decrease the need for so many consultations, perhaps.

Tom Tsang – ONC
What about the average number of hospital days for ... with selected conditions?

Niall Brennan – CMS/HHS – Deputy Director
Gosh, what was I thinking there?

Tom Tsang – ONC
Is that, for example, are you saying that for like congestive heart failure admission or pneumonia, a communicable pneumonia admission, that we have data on are you talking about length of stay?

Niall Brennan – CMS/HHS – Deputy Director
Yes, sort of. I know that that's to a certain extent somewhat immaterial ... Medicare ... perspective, but not necessarily for ... payers. Other folks, feel free to push back, but I was sort of thinking, again, relatively easy to compute or track might be more sensitive ... some of the other things that we're talking about, but let's say your congestive heart failure patient average 25 days a year and the national benchmark or norm is 12 to 15, so the 25 could be because of long length of stay or, again, it could be another sort of almost variation on a readmission measure. That's sort of what I was thinking there.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. We've worked at United on length of stay in the light of different areas. We find that it is related to defense and care and that we've had projects successfully where we decreased the defects and have decreased the length of stay and also decreased readmissions, which was very exciting, so it is good to couple with readmissions as we talked last week.

Tom Tsang – ONC
So, can I challenge the group in thinking like within an ACO context where it's a whole continuum and you're looking at the more longitudinal cross cutting approach to this, so can you wrap this up in a bundle of measures that's looking at the pre-acute stay care, as well as the acute care and even consider the post-acute care for that one condition? How can we have a bundle of measures for CHF along the various ... of care, encompassing not just the average number of hospital days, but I guess the—

Niall Brennan – CMS/HHS – Deputy Director
Family of measures for CHF.

Tom Tsang – ONC
Right. A family of measures, yes, for selected conditions.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. That works perfectly well, right? So in an out-patient world you want to make sure these people are on beta-blockers and maximal ace inhibitors and have had education and things like that. So those are NQF approved measures. Then you have the admission rate for CHF. Then you have the length of stay as an indicator of how well you're doing and a readmission rate as a balance to that for CHF. Then you have the transitional care measures, patient education and discharge planning, transmission of discharge planning to the primary care doctor, ... of medicines Then you have the receiving doctors picking up, so I think we actually have the pieces for that.

Tom Tsang – ONC
Then you add the functional status, patient self-reported data, which are the shortness of breath and their ability to take care of themselves, blah, blah, blah.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

And the ... score.

Tom Tsang – ONC
Right.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I'd just concur. We've gotten many of those pieces for heart failure as well. I'll say the one stumbling block for us is that since functional status or patient experience of care is because, as someone pointed out, it's different than what you might want to know from the patient if they have heart failure versus diabetes versus just had surgery on their knees. So that's something that we all need to put our heads together on.

Tom Tsang – ONC
Right. So there's a difference between patient care experience versus what the visiting nurse service would put into their home monitoring devices and how we get the biometric data into the EHR.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Well, and just what might be important to assess for somebody with heart failure would be different to assess for somebody, who had surgery on their knees.

Tom Tsang – ONC
Yes.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
What's important to that patient in terms of their outcome.

Tom Tsang – ONC
Yes.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
... potentially similar with coronary artery disease and diabetes and MI, I think, because we have some similar measures. The diabetes has kind of the bundle of process measures, the actual lab values, hypertension control, rate of admissions for diabetes related conditions—

Tom Tsang – ONC
So I'm kind of visualizing sort of like a longitudinal dashboard for this patient as they go across the continuum of care.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes and I can send everybody a sample.

Tom Tsang – ONC
Bob, any comments on this? Should we move on to—?

Bob Kocher – McKinsey & Company – Associate Principal
I think that's right. I think aspirationally we should try to do this for a couple of frequent episodes and I'm excited to see the sample. Why don't we move to the next bucket?

Tom Tsang – ONC
Okay. For the next bucket we actually don't have anything. I think this is where we left off at the population and preventive health measures.

Bob Kocher – McKinsey & Company – Associate Principal

Yes. To me, BMI would be ... thing to put here. I don't know what the goal is. I mean ... think of a goal, but it's ... to me feels like it's ... here and then ... could also go here. Hey, Rob, in the stuff that you sent do you have a comment about BMI?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Bob Kocher – McKinsey & Company – Associate Principal
Is there a way? You have obviously thought about this a lot. Is there any path to something that would be good on BMI?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
So that is something the EHR could produce, right? We could—

Bob Kocher – McKinsey & Company – Associate Principal
We could get the unit. We could ... whatever—

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Right and this goes back to finding the undiagnosed patient and risk factors. So we could start combining this with other information to find people at risk for diabetes. That was the particular example that I put there. Then we could also use it to risk adjust certain things, so joint replacement ... have comments on that and the general ... BMI ... abdominal surgery. So I think it's useful in a number of places, but especially with chronic diseases, like diabetes and CAD.

Bob Kocher – McKinsey & Company – Associate Principal
Okay. Maybe we would define through ... populations one would want to grab it or grab it for everybody, but there are certain places where it's useful. I didn't know about cancer screen rates or age appropriate screening. That felt like another spot where you would get measurement from the EHR. We know your age. We know your gender, so you could compare against that are your patients getting age appropriate screening or documentation for why they shouldn't?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
That reminds me; this is a little bit tangential and I apologize, but the EHR giving cancer stage information would be very useful and the treatment or not treatment status, because a lot of the things we do with cancer are limited. We don't know the stage and we don't know the treatment that's being done at the right stage or right time.

Bob Kocher – McKinsey & Company – Associate Principal
Yes. You also had, Rob, under the flu shot ... 64 and for older adults, which are already approved. I mean those fall in the bucket of they're approved. They're widely used. They're obviously going to be part of my EHR.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. Exactly. The problem that we have from a data point of view is people get flu shots in non-traditional settings. Hopefully that is captured in the EHR one way or another. That would be useful EHR data. My more general comment in terms of the cancer screening and under used things was they're absolutely important for all of the good social ... and such. Some of them are not necessarily cost efficiency related. Specific ones are, so flu shots I think have been proven to decrease population costs, especially over 65, but prenatal care. Then, under used measures in general with exceptions for some of the things we've discussed where they're kind of specific so that we connect them to a specific condition.

Bob Kocher – McKinsey & Company – Associate Principal
... beyond flu shots, age appropriate screening and BMI and smoking, are there others? Does anybody else have others to think about or others that we should ... future state category that ...?

Tom Tsang – ONC

Bob, is there anything more we can do with cardiac health or population based cardiac health in this category?

Bob Kocher – McKinsey & Company – Associate Principal
... salt—

Tom Tsang – ONC
... salt ...

Bob Kocher – McKinsey & Company – Associate Principal
Salt ... a big deal. Good question.

Tom Tsang – ONC
I mean there's been a national movement for the facts have changed to advertise their calorie counts and that's changed social behavior. I don't know if we can do something about calorie counts—

Bob Kocher – McKinsey & Company – Associate Principal
We can do something like here are the odds, sort of require patients to have ... sensors, but a ... that in the future they might become embedded in ... or something. Then we could get activity data on people and then I don't know. I don't know how we would get intake, but I saw a thing at the MIP ... not very easy. In one of their labs, where they have a cool, optical thing that could calculate your blood sugar continuously real-time and ... could figure out the number of calories flowing through your blood, but— I mean something like ... balance would be interesting. It was ... science fiction category today, but it would be worth having people think about it.

Tom Tsang – ONC
Interesting.

Bob Kocher – McKinsey & Company – Associate Principal
Activity is easier to get than calories, I mean just practically.

Tom Tsang – ONC
Kate, what are some of the folks talking about in terms of the population health measures, the NQF folks and some of the federal agencies?

Kate Goodrich – ASPE – CMO
Yes, so—

Bob Kocher – McKinsey & Company – Associate Principal
Kate, I'm sorry. I didn't mean to interrupt, but you could react to this too: At every meeting I've been going to lately people are pushing about patient literacy and health literacy as sort of a population health concept. I don't know how you can measure that either, so add that in to your answer, if you'd like ... too.

Kate Goodrich – ASPE – CMO
We're starting a new project with NQF for the ultimate endorsement of a bucket of population health measures and how those are defined has been, let's just say, an intense discussion. Should it be the types of things we've just been talking about related to BMI, tobacco cessation, etc.? Some people have suggested that we even look at various policies as measures. So we're not really sure what direction it's going to take yet. We're doing some sort of ground work to sort of flesh out exactly how we should be defining population health and what types of measures we should be calling for.

The likely outcome is though that we're ultimately going to at least initially hopefully endorse a set of measures or have them do a call for measures around some of the secretary's priorities, such as obesity, tobacco use, etc. But I think that there are a number of folks, who are hoping to sort of think a little bit more broadly and even looking at various policies as measures.

Tom Tsang – ONC
Would health disparities be considered under this bucket as well?

Kate Goodrich – ASPE – CMO
Yes, I think so. I like the idea of health literacy. It's definitely a pet area of my research that I've done as well and I think that that's really important and may well be something that the Steering Committee certainly considers.

Tom Tsang – ONC
So how about, as a measure of population health, whether providers are disaggregating their data to come up with intervention models for their sub-populations?

Kate Goodrich – ASPE – CMO
That as a measure in of itself?

Tom Tsang – ONC
Yes because in stage one we're requiring providers to collect race, ethnicity and gender, but if you're not doing anything with this data you're not just disaggregating it and doing the analysis. It's just sitting there and isn't much use.

Kate Goodrich – ASPE – CMO
Yes.

Tom Tsang – ONC
So closing the loop is coming up with ... models after you've done the disaggregate analysis and target interventions based on those sub-populations that have sub-par measures.

Kate Goodrich – ASPE – CMO
You mean that have measures that are not specific to specific sub-populations?

Tom Tsang – ONC
Having measures like if you find out your group of diabetics have hb1cs 10 or higher in certain sub-populations; what are you doing—?

Kate Goodrich – ASPE – CMO
To target them?

Tom Tsang – ONC
To target them. Yes.

Kate Goodrich – ASPE – CMO
Yes. Interesting. Not something we have talked about explicitly, but—

Bob Kocher – McKinsey & Company – Associate Principal
That really ... too some of the things we were talking about before with this that are targeting the outcomes on a population level is really an important idea. We should make sure we capture that. It probably falls into this bucket any other because I mean that's the point, right? If you have a population ... you have clinical data that says they're not being treated, like ... about hypercholesterolemia .... We would hope that in a future state, a future system with more care coordination and population responsibility that people would be ... making efforts to engage with those patients.

Tom Tsang – ONC
Yes. Niall, I'm interested what your thoughts are since you're in the ACO space, how you guys are thinking about the population that the ACO is taking care of and what kind of metrics you're thinking of.

Niall Brennan – CMS/HHS – Deputy Director

If I told you I'd have to kill you.

Tom Tsang – ONC
This is a public call. Remember that.

Bob Kocher – McKinsey & Company – Associate Principal
Yes ....

Niall Brennan – CMS/HHS – Deputy Director
Yes. We are struggling with this ourselves. I mean I will say personally, I'm not speaking for CMS, I do tend to struggle with finding good population or preventive health measures beyond the obvious ones that you guys talked about for the last couple of minutes, but we are exploring a range of possibilities in that regard.

Tom Tsang – ONC
Okay. Thank you. Well, I think we can move on, Bob, to the next bucket. This is something that we were kind of struggling with in terms of the name. This could actually mean two things. We put under use here, but we refer to metrics that focus on under used clinical tools rather than focusing on utilization, over utilization and at the same time it can also mean the concept of stinting of care where patients are essentially not receiving appropriate amounts of care. So we have a clean slate here for folks to suggest. Rob?

Bob Kocher – McKinsey & Company – Associate Principal
Rob, you have some.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Again, I don't want to dominate the conversation too much; that's why I was pausing for a moment, but yes. One of the things that occurred to me as we talked about this is that for our work we should be focused in the under use we address, so there are a lot of important, under used things in interventions that are very important from population health, from societal goals, etc., but we can focus, perhaps, more on some of the under used things that meet a specific goal. So thinking, for example, as we mentioned, if aspirin is under used for CAD it would prevent admissions and readmissions.

That was kind of the framework I was thinking of and then some of the things we've already talked about start fitting in, so the flu shots, the various medications for diabetic control, CAD and CHF. The pharmacy under use could fit into the pharmacy use row of the framework that I created. I was not sure if there should be a separate row in the framework I proposed for under used things with specific roles.

Bob Kocher – McKinsey & Company – Associate Principal
Mostly I think that ... to adherence and compliance to medications and then there's a subset where there was other tremendous evidence that uses ... clinical quality training if not life saving. So I think maybe ... abstract of some ... like ..., aces, Lipitor, steroid inhalers for COPD, SSRIs for depression, things where there would be some data that here it's very important and we want to maybe call it out as under use.

The other thing that came to mind was for chronic disease patients where there are good clinical guidelines, like ... diabetics. They have under use if you're not ... typing your ... and so ... encountered ... to have. The population health stuff around cancer screening is also going to be ... and under use ... that we want everyone to get their cancer screening, age appropriate screening. That will ... overlap a bit and actually look ... population health and then some of the other buckets, but—

Tom Tsang – ONC
I think we can also go beyond what the general population that we're thinking of in terms of mental health. For example, there's a measure of after you start antidepressants whether the patient is coming back for follow-ups, so that's sort of like under use of services and people are using the PHQ-9 to assess as an intermediary outcome. In terms of mental health that's one area. Then maybe in the area of prenatal

care, under use of services as well relating to outcome of either APGAR scores or some intermediary outcomes in terms of birth weights and so forth?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. That's absolutely right. The chronic care measurement, yes. Those things, like I said, prevent NICU stays. They prevent admissions. The mental health, I think there's potential for Medicare in treating mental health issues more aggressively because of the incidence of depression in elderly and such.

Bob Kocher – McKinsey & Company – Associate Principal
One other area too where we're right for measures if we can define some that are culturally acceptable would be around hospice use just given the variation and ... these types and market segments and different disparate populations ....

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. I think that's an excellent point. Again, that's supported with the data that's on the Dartmouth atlas, of course, in the last six months. I've seen a number of very good projects, for example, at the University of Rochester Medical Center in upstate New York. They instituted a mandatory palliative care consult for ICU admissions, so physicians didn't have to make a decision does this patient need a consult or ethics consult or palliative care consult. That, I believe, has had some very good results, kind of related to this question of hospice care and palliative care in general.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I'll just throw out that we might want to think about how whatever we put in this category, we send a signal that we're building on stage one because things like diabetes eye exam, those are in stage one. So again, terminology and to try to send the message that we're looking to build out our dashboard and maybe it's the way to think about our language again when we populate this segment.

Bob Kocher – McKinsey & Company – Associate Principal
Good point.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Once more, conscious this is a public call and some of the public issues related to palliative care and hospice care and potential misconceptions have appeared in the world, these are areas where we are asking to respect patient choice and patient autonomy.

Bob Kocher – McKinsey & Company – Associate Principal
I think ... some of that if he ... sort of the patient autonomy and respect that ... understood or something like that ... and so on.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. I just wanted to be very explicit that that's the context, because, if I may as a practicing physician and I saw patients for almost 20 years, I did see many situations where not considering hospice care palliative care resulted in potentially unnecessary suffering and sometimes did not respect patients' prior wishes and the movement to have these types of interventions and to think about them ahead of time has been, I think, very positive from a patient-centered view and from the experience of the patients that I took care of as well.

Tom Tsang – ONC
Well said. Others ... the last ... key areas of under use. Do others have suggestions based upon the work that you're doing of important areas that we should make sure ... familiar, either ... or process temp standpoint? I don't know, Kate or Niall, I imagine you guys think about this. Are folks still on?

Bob Kocher – McKinsey & Company – Associate Principal

I guess they're thinking so hard that they don't know the answer yet. Okay. It strikes me that mental health is a really important area. Prenatal care is a very important area. We've already talked about both of those. ... also some variations around adherence to clinical evidence that ... also and ... measures—

Tom Tsang – ONC
So, Bob, do you suggest us breaking this into, again, as we become a little bit more granular under this sub-domain than we have drugs and medications and procedures and then the third one could be—?

Bob Kocher – McKinsey & Company – Associate Principal
Maybe health promotions.

Tom Tsang – ONC
Yes.

Bob Kocher – McKinsey & Company – Associate Principal
I mean it just ... for drugs, but I think holistically the more we can broaden it the more value it will bet, particularly if you think about ... ACOs and ... and other ... models that might ... risk ... providers, an importance ... in safety and safeguarding function and under use measures that will give us confidence that not only are we going to get outcomes, but we're also not, in some cases, under treating. I guess I would think for wires to ... CHF to IBD, COPD where you can imagine ACOs are potentially focusing on them early that it would be wise to think about under uses majors that might target some of those areas, because you imagine that the market might be targeting these, so these are the ones we want to be most confident that we're not leading to ... cost point so under used ....

I'm making this up, but as an illustration for CHF, you can imagine that we wouldn't want there to be under use of cardiac testing or cardiologists, let's say or, God forbid, medications. But when we look at the set of metrics we have we're going to capture some of the RA and this is the ignition we talked about in the earlier buckets. We should at least do a test against for ... kinds of diseases where we think the prior ... entering in the new payment structures do we have any types of measurements to allow us to pick up an under treatment.

Tom Tsang – ONC
Yes.

Bob Kocher – McKinsey & Company – Associate Principal
And that's what you wear. I suspect when we're granular and we have ... my hypothesis is that these people have thought about that, so I think Niall and Cane and Charles and Rob and ... might have some ... for what those things could be. Maybe they're in a big bucket of future state, but I think it's important that a ... responder use.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
... throw like behavioral interventions into that bucket as well?

Tom Tsang – ONC
Yes.

(Overlapping voices.)

M
... which behavior?

Tom Tsang – ONC
Any behavior ... that you guys want to make sure we capture that for ... working on this. Which behavior did you have in mind?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Like behavioral interventions?

M
Yes.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I didn't have any particular one in mind. I mean there are certainly some evidence based behavioral intervention for ... and other areas, I think, as well. I didn't have a particular one in mind and I don't know what's out there, if there is even anything out there that is a feature type of measure.

Tom Tsang – ONC
Rob, I interrupted you. I'm sorry. You were jumping in.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Thank you. Again, so I think I understand the concern about we don't want to appear to duplicate the HMO experiment where people felt they were being under treated in the ACO world. So I think that's kind of the global point; that we don't have too many incentives for under treatment. Now, the current system of course, the incentives all tend to go the other direction and ... there is over use of many of these procedures.

I think that the key will be developing appropriateness measures, because those cut both directions. In other words, the ACC has appropriateness measures of the criteria for best ... tests and they are inappropriate, but they're also appropriate criteria. I think that will help us and I think that especially the importance of developing those criteria, many of which that long list of things I described. Many of those will be helped by that Excel file that I sent.

Bob Kocher – McKinsey & Company – Associate Principal
Okay. We're in an area where all of us ... and, Rob, the Excel file was certainly a good starter set, but I think creativity here and maybe there are a hand full of things too that fall into the next category of future developments, but this strikes me as very important as we think about new payment models to have; and you're right, appropriateness is really a nice way of thinking about it because we want to maximize the use of many things, so not under use .... Yes.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. We want them just right; not under; not over.

Bob Kocher – McKinsey & Company – Associate Principal
Like I said, we want Goldilocks measures.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Right.

Bob Kocher – McKinsey & Company – Associate Principal
Okay. Is there anything else going back across the buckets, as people have heard this conversation, is there any area ... missing from what we talked about or ... abnormalities in the current system or areas that we want to optimize more that we haven't touched on that we need to sort of ... that into our framework? Anything missing?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Bob, so the hospital acquired complications or conditions and infections, I know the Patient Safety Group is working on those, but I can't resist putting a plug in for them, because they do result in not only bad patient outcomes, but also such very high costs, multiples of the original costs.

Bob Kocher – McKinsey & Company – Associate Principal
You're right. You're right. Maybe those could map in our framework in a couple of spots so they're either under proven care or ... health systems.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes.

Bob Kocher – McKinsey & Company – Associate Principal
... conditions for sure, readmissions, absolutely. We would be remiss to not have them on the efficiency piece. Hopefully safety will be remiss about that among theirs. Good point.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I think this might be in left field, but it just occurred to me in talking about making sure care is not being withheld for any reason ... under use measures. You know, we're working now, as many have advocated, on composite measures. They're thinking about every patient getting everything for which they are eligible or for which is appropriate that they get. Again, this might be for another year from now, but maybe there's a way to say part of our looking at some of these under use areas is because eventually you want to think of them as a composite, just as sort of the check that these are all being offered to every patient, because the evidence tells us we believe they would impact the outcome.

Bob Kocher – McKinsey & Company – Associate Principal
Karen, that didn't seem like left field. That made perfect sense I think.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
I guess a lot of what I was getting at is just sort of maybe terminology and how we frame our recommendations.

Bob Kocher – McKinsey & Company – Associate Principal
Yes. Fair. I mean I like the spirit of what you're saying. Anybody else have thoughts for admissions that we should be adding in here for catching? So, Tom, should we talk about next steps at this point then?

Tom Tsang – ONC
Yes.

Bob Kocher – McKinsey & Company – Associate Principal
Let me make a recommendation or, Tom, do you want to?

Tom Tsang – ONC
No. Please go ahead, Bob.

Bob Kocher – McKinsey & Company – Associate Principal
I think what I propose to our working group at this point is we have a kind of incoming inputs now between these conversations and the various documents people have contributed; that we try to synthesize it into sort of a comprehensive set ... in the framework we have it all ... vendor, where we know the measure ... and we recommend them, where we have a good sense of ... and ... and then the prepared bucket of things we ... to help create ... to measure that then we can use as a stepping up point to either refine or ratify our next conversation. I would rather ratify it, go through it and ... edit it and work it into or begin shaping it into our final version, which then Charles, Tom and I would kind of just quickly go through and synthesize what we have here and ... e-mail first and then on the phone call. Does that make sense to folks? Are we comfortable with going to that next step?

Karen Kmetik – AMA – Director Clinical Performance Evaluation
That sounds fine to me.

Niall Brennan – CMS/HHS – Deputy Director
Sounds good.

Kate Goodrich – ASPE – CMO
Yes.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes. I agree and would add the velocity component.

Bob Kocher – McKinsey & Company – Associate Principal
Okay. So—

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Big, fast and ready to go should be the—

Bob Kocher – McKinsey & Company – Associate Principal
Okay. So, Tom, Charles and I will put our heads together over the next couple of days and try to combine everything into kind of a final first draft that we can then use as everybody can just have it in front of them and for our next conversation we can then run through it and see if we add and subtract our kind of market up and then we can reiterate that to our team in ....

Tom Tsang – ONC
Perfect. Great. There are a few housekeeping— Are we done, Bob?

Bob Kocher – McKinsey & Company – Associate Principal
I think for the non-housekeeping course we're done.

Tom Tsang – ONC
Great. Wonderful. I think today's call was extremely productive and very helpful. In fact, so much so that at some point in the homework portion we're going to have to prioritize because in certain domains we have perhaps, now with Rob's contributions, maybe ten measures in certain domains, so we're going to have to prioritize at least like what do we think are the top three or four or five.

But I just wanted to let folks know that we are having an in-person meeting on the 28th. All of you are welcome to attend. We do need either Bob or Charles to be there to present the recommendations to the overall workgroup. The hotel is, I believe, at the Sheraton National Hotel in Arlington, Virginia. It's not the ideal location, mainly because we have a number of large events in D.C. going on that particular week or weekend, the Marine Marathon being one of them and so we had a lot of problems finding a hotel that could accommodate the group.

Then Booz Allen, the associates and Susan, will help us draft a number of deliverables that we need to put together, which is a slide deck for the presentation, which will probably only be about four or five slides, the Excel spreadsheet and then a summary, kind of whitepaper recommendations.

Any questions? On the 28th it's probably going to be between 8:00 a.m. to 1:00 p.m. with the first hour and a half dedicated for public testimonies from various stakeholders.

Jon White – AHRQ/HHS – Director IT
Have you guys sent out the invites? Are you guys good with the invitations for the public testimony?

Tom Tsang – ONC
We haven't sent the invites yet. We are still narrowing down the list.

Jon White – AHRQ/HHS – Director IT
If you need any recommendations or anything else you should think about ....

Tom Tsang – ONC
If there are other folks that any of you think we should have, we have slots for four public commenters and they should represent various stakeholder groups, including consumers, patients, payers, major developers. Feel free to ping me if you have nominations. If there are no further comments I'm going to ask the operator to open it to public.

Operator
There are no comments.

Tom Tsang – ONC
Thank you, again, for everyone's efforts. I know this is really happening at light speed, so thank you so much for your time and effort. Thank you, Bob and Charles, if he's listening.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Good-bye, everyone.

Bob Kocher – McKinsey & Company – Associate Principal
My pleasure. Thank you to everybody. Thank you.